Review of compliance

Isle of Wight Council The Gouldings	
Region:	South East
Location address:	St Andrews Way Freshwater Isle of Wight PO40 9NH
Type of service:	Care home service without nursing
Date of Publication:	May 2012
Overview of the service:	The Gouldings is registered with the Care Quality Commission to provide the regulated activity of accommodation for persons who require nursing or personal care. The home is situated in Freshwater on the Isle of Wight. It provides care and support to a maximum of 35 older people who do not require nursing

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

The Gouldings was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 26 April 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We spoke with a number of people who were living at the home. To help us to understand the experiences of people, we spent time observing what was going on in the home. We observed how people spent their time, the support they received from staff and whether they had positive outcomes.

We observed interactions between the staff and people who use the service. People told us that they were treated with respect and that the staff were' very good and always there to help.' A person told us that they were 'very grateful' with the help and support they were receiving. They said that they were looking forward to going back home once their relative was well enough and was discharged from hospital. Other people told us that they came for 'respite care' and they had been at the home on previous occasions and this was 'fine.' Another person told us that they were there following a fall at home. They said that they would be going back to their own home as soon as they were' a bit stronger.'

People commented that the food was' very good' and they had plenty to eat and drink. They told us that they did not know what the menu was or what to expect for lunch. However they said that this was all right, as the meals were good. One person told us that they thought you can have something else if you did not like what was on the menu.

We also spoke to two visitors who were at the home during our inspection visit. They confirmed that their relatives were supported by staff to receive the care they needed and they were satisfied with the care.

People told us that they were offered choices and there was no restriction to time when

they got up or went to bed. People commented that the staff helped them and they liked living at the home.

What we found about the standards we reviewed and how well The Gouldings was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People's privacy, dignity and independence were respected when receiving care.

The provider was meeting this standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People's social and recreational activities were well managed and met with their satisfaction.

Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 05: Food and drink should meet people's individual dietary needs

People were provided with a choice of suitable and nutritious food and drink to meet their needs.

The provider was meeting this standard.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People who use the service were protected from abuse, or the risk of abuse, and people's rights were respected.

The provider was meeting this standard.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

People were at risk of not receiving their medicines as prescribed. The process for the management of medicines was not robust.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance

to develop and improve their skills

People benefited from staff who received regular training and were supervised, as part of their role in providing care.

The provider was meeting this standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

There was a lack of an effective system to regularly assess and monitor the quality of service that people received.

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People told us that they were treated with respect and their privacy and dignity was respected. They confirmed that staff consulted them and respected their wishes when providing care. They told us that they usually got up and went to bed when they were ready. They said that the staff supported them as needed.

People commented that the staff supported them to maintain their independence. They told us that the staff were very good and helpful.

Other evidence
We looked at a sample of four assessments and care plans. The care records showed that a placement form from a care manager was completed as part of their admission process. This contained details of the person's history, mobility, communication needs and assessments.

We observed that people were treated with respect and were offered choices with staff respecting the one made. The care records showed that people's preferences were respected and care and support were varied and took these into account. The staff's practices indicated that they considered people's privacy when providing personal care. Our observations and discussions with staff and the residents confirmed that people's

privacy was maintained. People's bedrooms were personalised. They said that they had been able to bring in items of personal belongings. We observed the staff knocking and waiting for a response prior to entering people's bedrooms.

People were provided with appropriate opportunities, support to promote their independence and community involvement with different groups involved in the home.

There were a number of people who were not able to participate in their care planning due to their cognitive ability. The care records lacked information about their likes and dislikes and their preferences. There was a lack of evidence to support how these service users were enabled to make, or participate in making decisions relating to their care or treatment. None of the care records were signed to indicate that the service users and or their relatives had been consulted about their care. Care records seen did not reflect if people had been consulted about and if they preferred to receive care from staff of the same sex.

Our judgement
People's privacy, dignity and independence were respected when receiving care.

The provider was meeting this standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People said that they were happy living at the home and they received help and support from the staff as needed. They said that the staff were very good and helpful. They were highly complimentary about the various facilities that the home had to offer.

A person told us that they had been at the home previously and knew what to expect. Another person said that they had been admitted from hospital and it 'was lovely and peaceful' at the home.

A person told us that they were 'very grateful' with the help and support that they were receiving. They said that they were looking forward to go back home once their relative was well enough and was discharged from hospital. Other people told us that they came for 'respite care' and they had been at the home on previous occasions and this was 'a lovely home.'

They told us that they enjoyed having the hairdresser coming to the home. They said it was 'like going out to the hairdresser.' People said that they enjoyed the activities provided. One person said' I look forward to the quiz.'

Other evidence
We looked at four sets of care plans,assessments and found that they provided some information about people's wishes and the way they wanted to be supported.

The home had some intermediate care beds which meant that people received care from other clinicians, including physiotherapist, occupational therapist and nurses for the community. This enabled people to be treated out of hospital and to return home within a short period of two to three weeks. Staff told us that this worked very well and adaptations were in place to promote and support people's independence. There was a dedicated area where people were supported to prepare meals and they had a 'breakfast club' on Tuesdays. Prior to discharge some people would have an occupational therapy assessment to ensure that any equipment needed could be put in place prior to them going home.

We had recently received some concerns about the lack of detailed assessments and care plans. The staff told us that they had since introduced a new care planning system. We found that information in the care records were variable. In three of the four records that we looked at, there were inconsistencies about the level of information recorded. We found that assessments had not been fully completed in order that a detailed care plan could be developed.

The home was providing care to a number of people who were receiving respite care. Although a detailed 'placement form' was available from social services. The staff had not used that information to develop care plans. This would ensure that people's assessed needs were clearly identified and action plans put in place to inform the staff's practices.

The staff told us that they were busy and some of these people were known to them as they came in at regular intervals. However, some were new and others came in less frequently. The manager confirmed that all assessments should be reviewed to ensure that any changes were identified. Staff could not explain why following assessments; detailed care plans had not been developed.

We found one care plan was detailed and contained good information about assistance needed and also what the person could do independently. They confirmed to us that staff assisted them with some parts of their personal care. Their assessment record showed that they were continent; the resident told us that they were not continent and this was causing them some problems. Staff told us that they needed support with managing their continence. Therefore there were some inconsistencies.

Two records indicated that people had been identified as moderate risk of falls. There were no care plans to show how this was being managed in practice. One of the residents identified as at risk of fall told us that they had problems moving about and used a frame and also had poor eyesight. However from the care plan it was not clear what support they were receiving in order to mobilise safely.

There was also a lack of assessments for people who were incontinent. Care plans had not been developed to indicate how staff would meet these people's needs. For one person the daily records showed that the person had been 'very very wet' and staff had assisted them. Not having a clear written care plan could put people at risk of receiving care in an inconsistent manner and not according to their assessed needs.

Another person's daily record showed that they were experiencing poor mobility and had a swollen left leg above their ankle. It was noted that a doctor was not called to see this person until two days later. They diagnosed a sprained ankle and advised for the

leg to be elevated. The manager told us that any concerns that were identified should be logged and this should be countersigned by the person in charge and any action taken. It was unclear why this did not occur and would be looking into the delay in seeking appropriate help for that person.

People were supported to access external health care support and advice. Staff confirmed that the healthcare teams were involved in managing pressure areas risks and the provision of pressure relieving equipment as needed.

There were adaptations such as assisted baths, showers and hoists were available to maintain and support people's needs. A passenger lift provided access to all the floors. We saw some of this equipment when we walked round the building.

There was a variety of activities that were available to the residents. These included one to one support to group activities. Some people attended the in house art classes and their art works were displayed around the home. We observed a quiz taking place in the lounge and this was interactive. People later told us that they enjoyed the activities. We were told that two of the residents were planning to set up a coffee afternoon. There was a 'memory club' that occurred on Fridays and we were told that this was well attended. We observed that the staff interacted well with the residents and were available in the communal areas throughout the day to assist the residents.

The hairdresser was at the home and a number of people were having their hair done. A designated room had been set up as a hairdressing salon. The hairdresser attended the home three days a week and we were told that people really enjoyed this service.

The home had a mobile 'shop' that was run daily by volunteers. We observed this enabled people to purchase small items such as toiletries and confectionaries. We were told that this was much appreciated by people who use the service.

Our judgement
People's social and recreational activities were well managed and met with their satisfaction.

Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People commented that the food was very good' and they had plenty to eat and drink. They told us that they did not know what the menu was or what to expect for lunch. However, they said that this was all right, as the meals were good. One person told us that they thought 'you can have something else if you don't like what's on the menu.' Three people told us that the staff came and always offered them a choice of desserts. They said 'they are good portions and the food taste all right.'

Other evidence
We observed the lunchtime meal and found that this was well presented and there was a choice for the main course and different desserts were available. One person told us that they were vegetarian and they had been provided with an alternative to the meat dish on that day. The chef told us that they were aware of people's likes and dislikes and dietary needs such as diabetic diets.

Staff were available in the dining room to offer support and assisted people with their meals in a sensitive manner. Plate guards were available in order to support people's independence at mealtimes. Meal time was relaxed and the lunchtime meal was taken at a leisurely pace. Staff told us that on Fridays they had two sittings as there were more people who attended the home for the social activity in the afternoon.

Throughout the day we observed that hot and cold fluids were available to the residents. People confirmed that they were offered hot drinks and snacks at bed times.

We were told that the staff went round and asked people what they wanted to eat and completed the menu. Staff said that the menu was also displayed in the corridor. We looked at the menu list and this contained only the main course and did not inform people of the alternative choice that was available. The manager told us that they were planning to introduce menu cards at the table. There were no menus in alternative formats to ensure that people were enabled to make informed choices.

We observed that the home had a meal list that was ticked at the end when all the meals had been served. These we found were not always accurate and did not accurately reflect people's dietary needs. A random sample showed that staff had recorded that people had not come down for breakfast or had refused their breakfast at that time. Staff said that people were supported to eat, however these were not always recorded on the diet list or in their daily records.

Our judgement
People were provided with a choice of suitable and nutritious food and drink to meet their needs.

The provider was meeting this standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us they liked living in the home and they could talk with the manager and the staff.
They told us that they received good care and felt safe living at the home. People said that they were treated with respect and the staff treated them well.

Other evidence
The home had in place a safeguarding policy and procedure which included the local authority safeguarding procedures. The manager described the procedure that they would follow and alert the safeguarding team as needed. There was a whistle blowing procedure in place and staff spoken with were aware of this.

An internal process and documentation was available for staff to refer any safeguarding allegations to the local authority. Following a recent investigation, we saw that an action plan had been developed. The manager was responsible for ensuring that these action points were completed and feed back to the team.

Staff we spoke with were able to describe the types of abuse that could occur and the action they would take if abuse was suspected. They were confident that they could approach the manager or the provider and actions would be taken to protect people.

They told us that they had completed training in safeguarding adults and we saw records of this. This training also formed part of the induction process for all staff.

Our judgement
People who use the service were protected from abuse, or the risk of abuse, and people's rights were respected.

The provider was meeting this standard.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
Most people were not able to tell us about their medicines due to their cognitive problems. Two people told us that the staff looked after their medicines and that was all right. One person said that they had their own medicines that they kept in their bedroom. Another person said that the staff helped them with their eye drops and they took their other medicines.

Other evidence
We looked at the process the home had in place to ensure that people received their medication as prescribed. There was a designated room that contained appropriate storage facilities and we saw these were kept securely.

We were told that a senior member of staff was responsible for the management of the residents' medication such as order and return. Some of the medication administration record (MAR) charts contained records of medication received into the home. A senior staff told us that they maintained a record of medicines returned to the pharmacist. We did not see this record as we were told this was with the pharmacist at the time of our visit.

The medication administration record (MAR) charts showed that there were no gaps and would indicate that people had received their medicines as prescribed. A random sample of people's medicines was looked at. This showed that there were discrepancies in the remaining stock with extra tablets that staff could not account for.

For people who were managing their own medicines, we saw there was a risk assessment for one of them. There was no evidence that a risk assessment had been completed for the three other people that we case tracked. We spoke to the staff about this and we were told for one person this had not been done as they came in for regular respite care. The manager confirmed that the home's procedure was that they should all be reassessed on admission, however this was not happening. This would ensure that any changes could be identified and appropriate action taken.

Another record showed that the staff were administering eye drops for one person who was self medicating. This was recorded on a 'task sheet' and not on the MAR record chart. The record showed that on three occasions the eye drops were administered incorrectly and not as prescribed. On one instant staff had administered the eye drop twice when only prescribed as once a day. On two occasions another eye drop was administered once a day when prescribed to be administered twice daily. A senior staff said that they would be looking into this error.

We also observed that staff had not given one dose of a medication; this was recorded as out of stock. It was unclear how this occurred as the medicine was in stock according to their record seen. Staff told us that they did not know why this medication had not been given.

There was a system in place where staff checked people's medicines weekly and records were seen. We found that a person had not received two dosages of a prescribed medicine as this was recorded out of stock on their MAR chart. We checked and found that this medicine was not available. Staff told us that this would be addressed.

We were told that a medication audit was in place. We requested to see this, but it was not available as we were told that the staff member responsible was not on duty.

Our judgement
People were at risk of not receiving their medicines as prescribed. The process for the management of medicines was not robust.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not speak to people about staff training. They said that the staff were available when they needed. They were 'very happy' with the care and support that they were receiving.

Other evidence
The manager told us that there was a training programme to support the staff in their role. All the staff completed an induction training programme when they started work. Staff spoken with confirmed this.

Recent training in March 2012 included hand hygiene, infection control; three staff had undertaken updates in dementia awareness. In February 2012, we were told that 18 staff had completed equality and diversity training in conjunction with the local college. The home had two staff members who had completed the train the trainer course for moving and handling. This we were told worked well and all new staff undertook this training on employment.

All senior staff that were responsible for medicines had recently completed training in safe management of medicines.

The staff were supported to undertake National Vocational Qualifications (NVQ) in care. We were told that some of the senior staff had requested to undertake the leadership in management course as part of their professional development.

Staff told us they received regular supervision to reflect on and discuss their practice.

We were told that the supervision of staff was shared between all senior staff which ensured these were not missed. The manager confirmed that all the staff had completed their personal development reviews. This consisted of a six monthly review and then end of year.

Our judgement
People benefited from staff who received regular training and were supervised, as part of their role in providing care.

The provider was meeting this standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People told us that they were happy to talk to the manager if they had any concerns about their care. People spoken with expressed satisfaction in relation to the care they were receiving.

They wanted to reassure us that they did not have any complaints and they liked living at the home. They said that the home was always very nice, clean and tidy. They also liked the different seating areas around the home that was available to them.

Other evidence
The home had an internal auditing system in place. This included a monthly assessment from the provider that looked at the overall management of the service. Feedback was then provided to the manager who would develop an action plan to address any problem as required.

There was a system for reporting and recording any accidents or incidents and action plans were developed to manage them. We were told that these were audited on a regular basis by the provider. We saw that the last audit of accidents and incidences was completed in December 2011.

There was a customer satisfaction survey. All new people who had been receiving respite care were sent out a satisfaction survey at the end of their stay. People were positive about the care they were receiving. We were told that meals at the home were

better managed following the employment of a permanent cook.

There was a complaint log of any concerns raised and action taken and responses. The manager told us that this was looked at in order to monitor any trends and an action plan developed as needed.

There was a process in place to assess risks and a regular audit of the environment was carried out. This included daily water temperature checks. Fire safety and fire equipments checks were carried out at regular intervals and a log was kept. The environmental health officer visited the home in March 2012 and the service had been awarded a five star rating in food hygiene.

As part of the development of the service, we were told that the communal toilets on the ground floor were due for refurbishment.

There was an audit system to look at medicines stock control on a weekly basis. However, their audit had failed to identify the issues we found in relation to the safe management of medicines. This included people not receiving their medicines as they were out of stock and the lack of risk assessments to ensure that people were safe to manage their own medicines.

The internal audit did not cover care planning and assessments. The lack of detailed care plans put people at risk of not receiving care in a safe and consistent manner.

Our judgement
There was a lack of an effective system to regularly assess and monitor the quality of service that people received.

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People's social and recreational activities were well managed and met with their satisfaction. Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: People were at risk of not receiving their medicines as prescribed. The process for the management of medicines was not robust. The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008	Outcome 16: Assessing and monitoring the

	(Regulated Activities) Regulations 2010	quality of service provision
	How the regulation is not being met: There was a lack of an effective system to regularly assess and monitor the quality of service that people received. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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